A REPORT REQUIRED BY CONGRESS ON PERFORMANCE PARTNERSHIPS:

A Discussion of SAMHSA's Efforts to Increase Accountability Based on Performance in Its Block Grant Programs by Instituting National Outcome Measures

"Government likes to begin things—to declare grand new programs and causes. But good beginnings are not the measure of success. What matters in the end is completion. Performance. Results. Not just making promises, but making good on promises."

President George W. Bush

September 2005

INTRODUCTION

In its reauthorization of the Substance Abuse and Mental Health Services Administration (SAMHSA) under the Children's Health Act of 2000 (PL 106 310), Congress called on SAMHSA to collaborate with the States and other interested stakeholders to develop a plan "for creating more flexibility for States and accountability based on outcome and other performance measures" in both the Community Mental Health Services Block Grant program and the Substance Abuse Prevention and Treatment Block Grant program, and to produce a report addressing:

1. The flexibility given to States;
2. The common performance measures to be used for State accountability;
3. Definitions for the data elements to be used;
4. Obstacles to plan implementation and ways in which such obstacles would be resolved;
5. Resources necessary to implement Performance Partnerships; and
6. An implementation strategy, "complete with recommendations for any needed statutory changes."

SAMHSA is committed to continuing to improve the management of its Block Grant programs in the same way it is proposing to manage its other major initiatives—by providing States with clear but limited requirements and standards for national outcomes data collection and by requiring accountability through performance. SAMHSA is equally committed to continuing to make resources available to States for performance reporting. SAMHSA has been working toward this vision for the past several years and is continuing to pursue this course of action with or without statutory change. At this time, SAMHSA remains committed to providing leadership for the development of performance measurement and accountability in SAMHSA's Block Grants, which can be done under current authorities without having to formally change SAMHSA's Block Grants into so-called "Performance Partnership Grants" or "PPGs." Indeed, SAMHSA is not referring to this initiative as "PPGs"; instead, this initiative focuses on instituting performance measurement in a consistent, focused way in, ultimately, all SAMHSA's programs, including its Block Grants. Although the overall process of developing performance measurement and accountability in SAMHSA's Block Grants is well established, it is not complete in every State at this time. SAMHSA is currently working with the States to assess their readiness to report National Outcome Measures (NOMs) data and to address their data infrastructure needs so that together they can begin this transformation. As SAMHSA embarks on these changes, we would like to discuss both our current activities and our plans with Congress. SAMHSA and Congress can then work jointly to identify what else may be needed for full implementation of accountability for performance in SAMHSA's Block Grants.

Since the Congress directed SAMHSA to submit this report, SAMHSA has initiated three major program initiatives: the Access To Recovery Program (ATR), the Strategic Prevention Framework (SPF), and Mental Health Systems Transformation (MHST). In addition, SAMHSA is now directing and coordinating the refinement of the agency's information systems to better inform management decision-making at the Federal, State, and local levels. To this end, SAMHSA's data strategy has moved the Agency's focus to a handful of key National Outcome domains, and NOMs for mental health, substance abuse treatment, and substance abuse prevention, in order to determine the impact of its major initiatives on the lives of the people it serves.

Background and Significance: Research and clinical experience have shown that people with mental and addictive disorders can and do recover when they receive timely and effective care in their communities. According to the National Survey on Drug Use and Health (NSDUH) administered by SAMHSA, in 2003, an estimated 22.2 million persons, aged 12 or older, needed treatment for an illicit drug problem or an alcohol problem, or both. In the same year, an estimated 19.6 million people, aged 18 or older, had serious mental illnesses. An estimated 4.2 million adults experienced a concurrent serious mental illness and diagnosable substance use disorder during the year. Further, in any given year, about 9 to 13 percent of children and youth have a serious emotional disturbance. From a programmatic and systems perspective, a limited number of key NOMs at the local, State, and national level—measured in structured, uniform ways by communities, States, and SAMHSA—can help inform the public about how well SAMHSA is meeting the needs of people with or at risk for mental and/or substance use disorders.

Intent of the Original Block Grants: When they were first created in the 1980s, the Block Grants' goals were to reduce Federal requirements and oversight, reduce Federal administrative overhead costs, increase State control and flexibility over the management of the Federal funds, and increase the responsiveness of these Federal funding programs to State and local needs and priorities. The Block Grants required limited fiscal accountability from the States for their administration of Block Grant funds through State audits and Federal compliance reviews. To implement these initial Block Grant requirements, SAMHSA simplified its management structures and reduced staffing, reviewing State Block Grant applications primarily for consistency with the requirements of the law. Although only providing between 2 and 3 percent of the total budget of States for community-based mental health services, the Community Mental Health Services (CMHS) Block Grant requires States to submit a State mental health plan emphasizing comprehensive, community-based services, including services for children, and targeted services for rural and homeless populations. The Substance Abuse Prevention and Treatment (SAPT) Block Grant, on the other hand, provides at least 40 percent of all public funds expended by the States for substance abuse prevention and treatment services. While the CMHS Block Grant contains few specific expenditure requirements, the SAPT Block Grant requires States to "set-aside" funding for services for pregnant addicted women and for HIV services.

Working with the States: For the past 10 years, SAMHSA and the States have endeavored to bring accountability for performance to SAMHSA's Block Grants. During this period, each of SAMHSA's Centers worked with the States to identify and test outcome measures. SAMHSA's CMHS has worked with State Mental Health Authorities to develop a mental health services data system, including the identification and specification of performance measures and data. This resulted in the CMHS Uniform Reporting System (URS) that contains over 20 measures of mental health services, which include the NOMs for mental health, each reported by States in the Block Grant application URS "data tables." CMHS has been able to make great strides in implementing the NOMs for mental health because of the availability of State Data Infrastructure Grants (DIG) to all States and Territories, and State reporting of Uniform Reporting measures began in fiscal year (FY) 2002 and continued in FY 2003 and FY 2004. During the past several years SAMHSA's Center for Substance Abuse Treatment (CSAT) convened over 30 SAMHSA/State substance abuse agency meetings on performance measurement and funded two "Treatment Outcome and Performance Pilot Studies" (TOPPS) that resulted in careful identification and delineation of outcome measures for substance abuse treatment. The foundation for the NOMs for substance abuse treatment presented in this Report, the outcome measures identified through TOPPS,

included changes in client alcohol and drug use, changes in client illegal activity, changes in employment status, and changes in homelessness. Many States have been reporting on these measures voluntarily since 2000, and are now poised to fully implement reporting on the NOMs. In addition, the States receiving the ATR grants will pilot test NOMs that are still "developmental" for substance abuse treatment. Finally, over the past 5 years, SAMHSA's Center for Substance Abuse Prevention (CSAP) and a group of State prevention officials met regularly to identify and define performance measures, including the agreed-upon NOMs for substance abuse prevention that are now being reported, as well as the developmental NOMs that are being pilot tested by States receiving the Strategic Prevention Framework (SPF) State Incentive Grant (SIG) program.

SAMHSA Promoting Leadership: A significant function of developing consistent NOMs is to create a basic national data set. In accord with a number of recent national concerns regarding the quality of America's health care systems including mental health care, SAMHSA firmly believes that it is a part of its responsibility to the American public to use the funds and authority granted to SAMHSA to promote and leverage leadership in improving quality of care. Through encouraging the development of these particular domains and outcome measures that are broader and more recovery-based than simply reporting numbers of consumers served, or beds occupied, it has facilitated the use of data and outcomes to provide information regarding real outcomes for real people. This process has enabled SAMHSA to promote enhanced quality throughout the United States and to raise the bar for quality services. This is possible in 2005 because we now have access to many effective treatments and services that enable persons with mental illness and substance use disorders, and help those at risk for such disorders, to be able to pursue a meaningful life in their community.

As an illustration of SAMHSA's commitment to performance measurement, it will have invested over $315 million in data infrastructure and related technical assistance to the States over the past 6 years. Such activities have included technical assistance to States, support for State data infrastructure development, and State needs assessment support.

SAMHSA RESOURCES FOR PERFORMANCE MEASUREMENT AND PERFORMANCE MANAGEMENT (in millions)

SAMHSA Center	FY 2001 Actual	FY 2002 Actual	FY 2003 Actual	FY 2004 Actual	FY 2005 Estimate	FY 2006 Request	Total
CMHS	$12.2	$12.6	$13.7	$16.0	$16.5	$13.1	$84.1
CSAP	$10.1	$10.6	$8.5	$12.2	$19.9	$19.9	$81.2
CSAT	$22.8	$25.4	$26.8	$11.9	$15.0	$14.4	$116.3
OAS	$3.9	$3.9	$4.0	$4.1	$9.1	$8.5	$33.7
Total	$49.0	$52.5	$53.0	$44.3	$60.5	$55.9	$315.3

SAMHSA continues to work with the States to address their concerns and needs regarding moving to more performance-based Block Grants. SAMHSA published its initial plans for comment in the *Federal Register* on December 24, 2002. SAMHSA received 73 comments on the proposals for substance abuse, 30 of which were from States, and it received 42 comments on the mental health proposals, 18 from States. To a large degree, this Report addresses and responds to those comments, as does the implementation of the NOMs for SAMHSA's Block Grants, undertaken jointly by SAMHSA and the States.

In general, most States embraced performance partnerships in their comments on the *Federal Register* notice, believing that their primary benefit would be the emphasis they place on accountability for performance and outcomes—"better care and services to clients"—not merely for expenditures. Respondents also applauded the emphasis on incentives and continuous quality improvement, rather than on penalties. However, State mental health and substance authorities are concerned about the "significant" cost of implementation for both hardware and software and for personnel and training, and are also concerned about being held accountable for outcomes that are not within their direct responsibility or control (for example, reduced homelessness or criminal justice involvement). States also called for simplified and standard formats for States' reporting to SAMHSA. Indeed, the basic goal of SAMHSA's implementation of NOMs is to streamline reporting.

Two years after SAMHSA's initial proposal was published, SAMHSA met with State substance abuse officials to agree on the final and developmental NOMs for substance abuse prevention and treatment, as well as the next steps needed to implement full reporting by FY 2007. Similarly, for mental health, SAMHSA will be meeting with State mental health officials to finalize the NOMs for mental health, which are well underway. In fact, most of the States are able to report on eight of the ten NOMs for mental health, and work is proceeding to define and pilot test NOMs for the remaining two developmental areas.

Responding to OMB Program Assessment Rating Tool (PART) Review: SAMHSA and the States are currently working on many related data collection and infrastructure activities, including the identification and refinement of the NOMs for substance abuse and mental health, and specification of State technical assistance needs. SAMHSA is also working to address the needs for performance measurement identified by the Office of Management and Budget (OMB) in its 2003 review of SAMHSA's management of both Block Grant programs as part of its PART process. OMB recommended that SAMHSA help States strengthen their ability to assess program results and accountability by: (1) developing targets and measures; (2) conducting program evaluations; (3) linking budget proposals to program performance; (4) sharing performance information with the public; and (5) demonstrating progress in achieving goals. OMB explicitly recognized that SAMHSA's move toward measuring performance in its Block Grants will help address these areas of greatest need.

Vision for the Future: All of these efforts have influenced SAMHSA's policy on improving the Block Grants into more performance-based programs and have contributed to SAMHSA's ability to take the crucial step to identify and institute reporting on NOMs across all of its programs, Block Grant and discretionary. As noted earlier, SAMHSA and the States have identified seven key National Outcome domains, including: abstinence from alcohol abuse or drug use, or decreased mental illness symptomatology; increased or retained employment and school

enrollment; decreased involvement with the criminal justice system; increased stability in housing; increased access to services; increased retention in services (substance abuse) or decreased utilization of psychiatric inpatient beds (mental health); and increased social supports/social connectedness. These seven domains, as well as three outcomes identified by the OMB PART process—client perception of care, cost effectiveness, and use of evidence-based practices—constitute the ten National Outcomes.

Focusing on this handful of National Outcomes for the Block Grants, as well as for all SAMHSA's major initiatives, will minimize the reporting burden on the States and will enable SAMHSA and the States to effectively monitor client outcomes and help direct systems improvements. SAMHSA is currently finalizing standard definitions for the specific NOMs for substance abuse treatment, substance abuse prevention, and mental health services, and plans to adopt standard information technology tools and platforms to support the collection of the NOMs and other data needed by the agency. It is also planning to take additional steps to simplify and consolidate reporting requirements on the States and other grantees. Other key elements of SAMHSA's vision for the future or data strategy include the adoption of a set of "Guiding Principles for Implementing SAMHSA's Data Strategy" shared with the States in December 2004, the definitions of the NOMs (data standards), and the actions steps taken in FY 2005 and proposed in FY 2006 in the President's Budget Request for FY 2006, as well as in this Report to Congress. The data strategy also includes the development of Enterprise Architecture (as documented on the Department of Health and Human Services website) to align SAMHSA activities with SAMHSA mission and realign resources after removing redundancy in programs, activities, and support programs. The 3-year transition period begins in FY 2005, and all States will report on all NOMs by the end of FY 2007.

States will report on the NOMs listed in the chart on page 13, beginning in FY 2005. SAMHSA and the States will assess State readiness to report on the NOMs, and will work together to gather data and develop "national and State pictures" beginning in FY 2005.

In addition to implementing NOMs in its Block Grants, SAMHSA's key initiatives will also address these National Outcomes. These four initiatives will give SAMHSA and the States valuable field experience with NOMs before their full implementation in the Block Grants:

1. The **Access To Recovery (ATR) grant program**, announced in March 2004, is a voucher program that provides client choice among substance abuse clinical treatment and/or recovery support service providers, expands access to a comprehensive array of clinical treatment and recovery support options (including faith-based programmatic options), and increases substance abuse treatment capacity. Monitoring outcomes via the NOMs for substance abuse treatment, tracking costs, and preventing waste, fraud, and abuse to ensure accountability and effectiveness in the use of Federal funds are also important elements of the ATR program. Through the ATR grants, grantees will have flexibility in designing and implementing voucher programs to meet the needs of clients. The key to successful implementation of the voucher programs supported by the ATR grants will be the relationship between the grantees and clients receiving services, to ensure that clients have a genuine, free, **and** independent choice among eligible providers. States are encouraged to support any mixture of clinical treatment and/or recovery support services that can be expected to achieve the program's goal of achieving cost-effective, successful outcomes for the largest number of people, and expand

substance abuse clinical treatment and/or recovery support services, while increasing accountability in the substance abuse treatment system. As indicated earlier, States and tribes that have received the ATR grants will pilot test measures for the remaining "developmental measure" for substance abuse treatment, the measure for social connectedness.

2. In FY 2004, SAMHSA also implemented the **Strategic Prevention Framework (SPF) State Incentive Grant (SIG)**. This new $61 million competitive SPF Grant Program is enabling States, Territories, and the District of Columbia to bring together multiple funding streams from multiple sources with the common goal of creating and sustaining a community- and evidence-based approach to substance abuse prevention and mental health promotion and mental illness prevention. The Framework conceptualizes prevention as a five-step process to promote youth development, reduce risk-taking behaviors, build on assets, and prevent problem behaviors in all areas of a young person's life—at home, at school, and in the community. The five steps are: (1) profile needs and response capacity; (2) mobilize and build needed capacity; (3) develop a prevention plan; (4) implement programs, policies, and strategies based on what is known to be effective; and (5) evaluate program effectiveness, sustaining what has worked well. SAMHSA's vision is that the SPF will provide the structure around which all of our prevention resources are aligned. As part of this initiative, the Agency is committed to working with the States to pilot test developmental substance abuse prevention NOMs that they have identified, including developing measures for social connectedness and retention, and finalizing measures for criminal justice involvement, returning to/staying in school and employment, and cost effectiveness. These measures will also be used to track performance of the substance abuse prevention portion of the SAPT Block Grant.

3. **Mental Health System Transformation (MHST) grants** are SAMHSA's newest response to the President's Executive Order establishing the New Freedom Commission on Mental Health, which issued its final report in July 2003. Transforming the current mental health delivery system has been given a new sense of urgency based on this report, which found the system in need of a wholesale change. This transformation involves consumers and providers, policymakers at all levels of government, and both the public and private sectors. SAMHSA was tasked by the Administration to review the Commission's report and to develop an action agenda to achieve the goals for transformation outlined by the Commission. Already, SAMHSA's FY 2005 budget includes a new $20 million State-based grant initiative to begin the process of transforming mental health care in America. SAMHSA is developing an action agenda to address the President's Executive Order. One goal is to create comprehensive State mental health plans that will improve the use of existing resources to serve people with mental illness. SAMHSA is committed to use the NOMs for mental health to measure the overall impact of transformation on client outcomes and, specifically, to measure the performance of the CMHS Block Grant Program. The State NOMs data will be capable of painting a State and national picture of the operation of the State mental health agencies, and how clients are doing in these agencies. Eventually, SAMHSA and the States will be able to compare the performance of the public mental health system (based on NOMs data) with the private mental health systems (based on data from national surveys.)

4. SAMHSA's fourth major initiative is the **Co-Occurring State Incentive Grants (COSIG)** program. SAMHSA released a landmark Report to Congress on Co-Occurring Disorders which mapped out a **Five-Year Blueprint for Action** that will guide agency leadership to

ensure accountability, capacity, and effectiveness in the prevention, diagnosis, and treatment of co-occurring substance abuse and mental disorders. The COSIG was developed as part of a comprehensive response to this Report and provides funding to States to develop and strengthen the infrastructure of States and their prevention and treatment services service systems. States with COSIG grants will begin to report on both mental health and substance abuse NOMs listed on the chart later in this report, beginning in FY 2005. SAMHSA and the States will assess the readiness of the COSIG and other States to report on NOMs for clients with co-occurring disorders.

ITEMS REQUIRED TO BE ADDRESSED IN SEC. 1949 OF THE PUBLIC HEALTH SERVICE ACT

The remainder of this Report will specifically address the six items requested by Congress in mandating this Report.

FLEXIBILITY GIVEN TO THE STATES

SAMHSA's Block Grant programs already provide a great deal of flexibility for States in their substance abuse and mental health services programming. For example, several States, including Michigan, Pennsylvania, and Wisconsin, have used CMHS Block Grant funding to support programs that address homelessness. Nevada's Consumer Assistance Program (CAP) enables eight Consumers Services Assistant staff to develop their own work and career skills while helping other consumers through a range of individual support and advocacy activities. While States do have considerable flexibility in the SAPT Block Grant to develop plans and fund a variety of substance abuse services, the statutory requirements in the SAPT Block Grant provisions for targeted funding and mandatory reporting that have been added over the years have limited State flexibility.

SAMHSA does not currently require States to report on outcome data nor to make progress on their performance goals. Currently, reporting on NOMs is voluntary. However, States have agreed to report on SAMHSA's NOMs for mental health and substance abuse, beginning in FY 2005. Although SAMHSA may continue to encounter resistance from some States to reports showing specific State performance on these NOMs, there is general agreement that national and State "pictures" of substance abuse and mental health services are needed to demonstrate need and to underscore the fact that these services are effective. Through its data strategy, SAMHSA is setting consistent definitions and standards for State NOMs data and will undertake, in partnership with the States, the aggregation and analysis of State performance data to derive national performance estimates.

Rather than discuss NOMs implementation in the context of "incentives and penalties," SAMHSA and the States have agreed to collaborate on generating national and State "pictures" of substance abuse and mental health services that will provide the public and policymakers at all levels with the information they need to make policy and funding decisions. SAMHSA firmly believes that such information will benefit both the States and SAMHSA as they work to provide effective services for the people receiving their services.

Under SAMHSA's new program to support State systems development for reporting NOMs data, the State Outcomes Measurement and Management System (SOMMS), funding will go to States reporting NOMs data only after their NOMs data have been checked for quality and accuracy. Many States will be able to report NOMs information, because these data are currently reported to SAMHSA through the National Survey on Drug Use and Health (NSDUH), the Drug and Alcohol Services Information System (DASIS), which includes the Treatment Episode Data Set (TEDS), or CMHS's Uniform Reporting System (URS). SAMHSA is also planning to purchase various data from the States, provided that the data meet SAMHSA's standards.

The Agency has incorporated the NOMs in the Block Grant applications, and will continue to devote resources to State data collection, analysis, reporting, and technical assistance, working with the States to detail and address their specific technical assistance needs. SAMHSA's Centers will continue to align their initiatives so that SAMHSA's discretionary portfolio—its technical assistance and data infrastructure activities—clearly supports the service needs and priorities of the States identified through the Block Grants. At this time, SAMHSA is developing a 3-year implementation plan, which it will work with the States to finalize, to institute full reporting of the NOMs for substance abuse by the end of FY 2007. A key element of this plan is targeted technical assistance for States that cannot currently report NOMs and data infrastructure support for the States that can. In addition, clearly SAMHSA will reduce the burden on States by collecting a single set of NOMs for both Block Grants and discretionary grants, eliminating unneeded data requirements and enabling SAMHSA itself to generate both national and State data reports.

COMMON PERFORMANCE MEASURES AND DEFINITIONS OF DATA ELEMENTS

As indicated, SAMHSA has adopted a limited set of NOMs that are applicable to its key initiatives, including the Block Grants. Ultimately, SAMHSA intends to obtain outcome data from the States, which will in turn work with providers to gather outcome data from the provider level up. SAMHSA and the States have been grappling with specific issues related to gathering such information at the provider level, and SAMHSA will continue to provide technical assistance and support to the States in these efforts. Gathering information on a common and focused set of measures that track these National Outcomes will help SAMHSA, the States, and communities to avoid collecting data that ultimately are not used to tell us whether we are making a difference in the lives of the people we serve.

NATIONAL OUTCOMES

The National Outcome domains have been identified earlier in the section, "Vision for the Future." Measuring these National Outcomes will enable SAMHSA and the States to assess whether the substance abuse and mental health services funded by the Block Grants lead to better results for the people served, on a State-by-State basis. By using the same outcome measures over time to assess progress toward State-established targets, States and SAMHSA will create a "feedback loop" to foster continuous program and policy improvement. The National Outcomes will also ultimately be measured and tracked in SAMHSA's discretionary programs.

As indicated above, SAMHSA and the States are developing a 3-year implementation strategy that will equip States to tailor current data systems to incorporate consistent data definitions and use the same standards for aggregating and analyzing performance data. While States may not achieve

complete uniformity in the data they collect due to differences in capacity and/or the nature and extent of behavioral health care needs, services, and systems design, these standards and consistent data definitions will lead to the aggregation of the data to provide a "national picture" of progress toward serving people with or at risk for mental or substance use disorders. SAMHSA will report these nationally aggregated data—with qualifiers as needed—in standard periodic and special reports, and will continue to work with the States to improve reporting capacity.

Clearly, full implementation of reporting on the National Outcomes will need to be phased in over this 3-year period, given the variability in State capacity. A careful and full assessment of State capacity has begun, along with targeted technical assistance for the States on data collection, reporting, and analysis. During this phase-in period, more and more States will be reporting on the National Outcomes as State capacity is built and improved. For example, at this time:

- Thirty States can report on at least some of the NOMs for substance abuse treatment. SAMHSA anticipates that another 16 States will be able to report on NOMs in FY 2006 by implementing SOMMS.
- For substance abuse prevention, much of the State data required for the Abstinence domain—no use in the prior 30 days, perceived risk of use, age of first use, and perception of disapproval—are captured in SAMHSA's NSDUH, and SAMHSA's CSAP has State-by-State information on cost effectiveness (cost bands) and use of evidence-based practices. In addition, 21 States now have SPF SIG grants, enabling them to establish Epidemiology Workgroups and gather comparable data from States, counties, other localities, and programs.
- For mental health, 40 States can report on most of the NOMs in CMHS's URS. CMHS will analyze the FY 2004 URS data this spring to prepare a report on NOMs that will paint State and national pictures of the operation of the State mental health agencies, and how clients are doing in these agencies. These activities are financed through State DIGs and a related contract support center.

NATIONAL OUTCOME MEASURES

SAMHSA has worked carefully with the States to identify and agree upon specific NOMs to measure the National Outcome domains. Data on specific populations, including women and children, and racial and ethnic minorities, are being and will continue to be captured by these measures. The NOMs are used synonymously in this section with the Congressional term "data elements." In this way, the majority of specific components of each measure already are known to and in use by many States, and come from existing data sets. (The specific NOMs for mental health, substance abuse treatment, and substance abuse prevention are provided in the chart on page 13 later in this section.) In addition as indicated earlier, through its data strategy, SAMHSA is completing standard data definitions for all elements needed by the agency, including the NOMs. SAMHSA is adopting standard information technology tools and platforms to support its data collection efforts and consolidating multiple client-data systems. Throughout these efforts, SAMHSA will ensure that its standard data definitions are aligned with the Health Insurance Portability and Accountability Act (HIPAA) and other standard industry definitions. Finally, as noted earlier, each of SAMHSA's Centers will be working with SAMHSA's Office of Applied Studies (OAS) and the States to gather and analyze available NOMs data in the spring of 2005 to paint national and State pictures of substance abuse and mental health services.

MENTAL HEALTH NATIONAL OUTCOME MEASURES

Since its inception, SAMHSA's CMHS has worked with the States to develop a mental health services data system, including the identification and specification of performance measures and data. This resulted in the CMHS Uniform Reporting System (URS) that contains over 20 measures of mental health services; each reported by States in URS "data tables" in their CMHS Block Grant applications. Today, many States can already report on the NOMs for mental health contained in the URS that are listed on the chart on page 13. CMHS has been able to make great strides in implementing the NOMs because of the availability of State DIGs to all States and Territories. State reporting of Uniform Reporting measures began in FY 2002 and continued in FY 2003 and FY 2004. Many improvements are underway, including the goal of unduplicated counts of all persons served; some States can currently do this, and others are working toward this goal. Further, as outlined in the section containing milestones of NOMs implementation (pages 19–21), SAMHSA and the States will continue to improve reporting on mental health NOMs through the DIGs in Autumn 2005, will determine the final data elements for developmental measures in Winter 2005–2006, and will continue to refine and finalize NOMs throughout 2006, leading to full reporting of NOMs by October 2007.

In FY 2005, CMHS will work with the States to finalize two developmental NOMs, on social connectedness and on reduced symptomatology/improved functioning. CMHS will also be revising specific national surveys to include NOMs in order to be able to paint a national picture of the entire organized mental health system. In FY 2006, CMHS plans to have FY 2005 URS data from the States and anticipates that more States will be able to report on more of these measures. CMHS also plans to have preliminary results from the reinvented Client/Patient Sample Survey. Once SAMHSA has these pictures, then SAMHSA will be able to compare the entire organized mental health system with that component operated by the State mental health agencies, both at the national and State levels.

SUBSTANCE ABUSE PREVENTION NATIONAL OUTCOME MEASURES

SAMHSA has also worked carefully over the years with State substance abuse prevention officials to specify and define performance measures for substance abuse prevention activities. Since 1990, SAMHSA's CSAP and a group of State prevention officials have met regularly to identify and define the 30+ performance measures currently being addressed by the States as part of the SIG program, many of which are taken from existing data sources, such as CSAP's Minimum Data Set (MDS) or its Core Measures Initiative. To a large degree, the current NOMs for substance abuse prevention have been taken from that larger list of measures. See the chart on page 13 for further detail on the final and developmental NOMs for substance abuse prevention.

Much of the State data required for the Abstinence domain—no use in the prior 30 days, perceived risk of use, age of first use, and perception of disapproval—are captured in SAMHSA's NSDUH. Also, CSAP has State-by-State information on cost effectiveness (cost bands), and use of evidence-based practices. The pilot testing of developmental measures for substance abuse prevention will be led by the 21 States that now have SPF SIGs, since they have been able to establish Epidemiology Workgroups and to build capacity to gather comparable data from States, counties, other localities, and programs.

SUBSTANCE ABUSE TREATMENT NATIONAL OUTCOME MEASURES

Currently, the SAPT Block Grant and ATR grant program measurement strategy to capture the NOMs for substance abuse treatment builds upon the foundation of the TEDS admission data that is generally available for most publicly funded clients throughout the States. The NOMs, which are listed on the chart on page 13, will require data collection at date of first service and date of last service in order to collect these measures of client change. Information produced through an assessment of the States conducted by the National Association of State Alcohol and Drug Abuse Directors (NASADAD) indicates that most States exceed the minimum specifications of TEDS and are now collecting many of the relevant variables at discharge.

Beginning in FY 2005, SAMHSA will initiate the SOMMS to support expansion of current State data collection efforts to the requirements of the agreed-upon NOMs for substance abuse treatment, building on the technical assistance currently provided by CSAT and through TEDS. SOMMS contains two major components, SOMMS Central Services which will provide ongoing support to States for their development of performance measurement and management capacity, and the State Payments to States with demonstrated ability to report NOMs data, for reporting infrastructure development and maintenance.

DEVELOPMENTAL MEASURES

As indicated, some of the specific NOMs listed above are "developmental," requiring further work by SAMHSA and the States to delineate the best measures to assess progress toward reporting National Outcomes; a result of such work may be an agreement that the outcome is not applicable (to prevention, for example). Developmental measures include: 1) those for which there is general agreement on the measures but the measures need to be finalized; and 2) those outcomes for which a measure(s) needs to be identified. In the first category—for which measures have been defined, but need to be tested and refined—are the following: For mental health, such measures include those for criminal justice involvement, school attendance, readmission rates, and number of persons receiving evidence-based services. For substance abuse treatment, such developmental measures include that for social connectedness, for which a measure has been developed in ATR and is currently being tested by ATR States. For substance abuse prevention, measures have been identified but need to be tested and refined for criminal justice involvement, return to/stay in school/employed, and cost effectiveness. SAMHSA plans to work with those States receiving SPF SIGs to test and refine the measures that have been identified for these domains.

Developmental measures in the second category—for which a measure(s) need to be identified—include the following: For mental health, measures need to be identified for reduced symptomatology/increased functioning and for social connectedness. SAMHSA is currently working with the States through the National Association of State Mental Health Program Directors' (NASMHPD) National Research Institute to identify and test such measures. For substance abuse treatment, measures need to be identified for use of evidence-based practices and client perception of care. SAMHSA plans to work with those States receiving ATR grants to pilot test various measures for these domains and identify the most effective ones. For substance abuse prevention, a measure(s) for social connectedness needs to be identified. As indicated above,

SAMHSA plans to work with those States receiving SPF SIGs to develop and pilot test this measure.

As SAMHSA and the States refine and finalize NOMs measures, clearly discussion will need to center on the rationale for using different measures for the same National Outcomes and on whether and how SAMHSA and the States should work toward a single measure for each domain, thus streamlining reporting burdens for all SAMHSA grantees.

MEASURES FOR CO-OCCURRING DISORDERS

States with COSIG grants will begin to report on both mental health and substance abuse NOMs listed on the chart later in this Report, beginning in FY 2005. SAMHSA and the States will assess the readiness of the COSIG and other States to report on NOMs for clients with co-occurring disorders.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
NATIONAL OUTCOME MEASURES

(as of September 2005)

OUTCOME	TREATMENT		PREVENTION
	Mental Health	**Substance Abuse**	**Substance Abuse**
Abstinence from Drug/ Alcohol Abuse	NOT APPLICABLE	Reduction in/no change in frequency of use at date of last service compared to date of first service	No use in the prior 30 days
			Perceived risk of use
			Age of First Use
			Perception of Disapproval
Decreased Mental Illness Symptomatology/Functioning	*Developmental*	NOT APPLICABLE	NOT APPLICABLE
Increased/Retained Employment or Return to/Stay in School	Profile of adult clients by employment status. Increased school attendance (children)	Increase in/no change in number of employed or in school at date of last service compared to first service	ATOD suspensions/ expulsions; school attendance over enrollment; workplace AOD use
Decreased Criminal Justice Involvement	Profile of client involvement in criminal and juvenile justice systems	Reduction in/no change in number of arrests in past 30 days from date of first service to date of last service	Drug-related crime; alcohol-related car crashes and injuries
Increased Stability in Housing	Profile of clients' change in living situation (including homeless status)	Increase in/no change in number of clients in stable housing situation from date of first service to date of last service	*Developmental*
Increased Access to Services (Service Capacity)	Number of persons served by age, gender, race and ethnicity	Unduplicated count of persons served; Penetration rate – Numbers served compared to those in need	Number of persons served by age, gender, race and ethnicity
Increased Retention in treatment – substance abuse	NOT APPLICABLE	Length of Stay - from date of first service to date of last service	Total number of evidence-based programs and strategies
		Unduplicated count of persons served	
Reduced utilization of psychiatric inpatient beds – mental health	Decreased rate of readmission to state psychiatric hospitals within 30 days and 180 days	NOT APPLICABLE	NOT APPLICABLE
Increased Social Supports/Social Connectedness [2/]	*Developmental*	*Developmental*	*Developmental*
Client Perception of Care [1/]	Clients reporting positively about outcomes	*Developmental*	NOT APPLICABLE
Cost Effectiveness (Average Cost) [1/]	Number of persons receiving evidence-based services/ Number of evidence-based practices provided by state	Number of States providing substance abuse treatment services within approved cost per person bands by the type of	Increase services provided within cost bands within universal, selective, and indicated programs
Use of Evidence-Based Practices [1/]		*Developmental*	Total number of evidence-based programs and strategies

[1] Required by 2003 OMB PART review; [2] For ATR, this is measured by client participation in voluntary recovery/self-help groups and interaction with supportive family and/or friends.

[Note: For the current version of the NOMs grid, see http://www.nationaloutcomemeasures.samhsa.gov/./outcome/index.asp.]

OBSTACLES TO IMPLEMENTATION; RESOLUTION OF OBSTACLES

The understanding and acceptance shared by the States and SAMHSA—that accountability for performance in the Block Grants is a needed reform—have helped minimize or eliminate many potential obstacles to implementation. However, a key obstacle, resistance to change, is not easily solved and must be addressed continually during transition reporting on NOMs in SAMHSA's Block Grants.

Resistance to Change: Organizational cultures, in the past, have not always welcomed or fostered the use of information in decision-making. Previously, in both SAMHSA and the States, processes that support the use of data to make decisions or improve programs have often been compromised or missing, and staff capacity to synthesize information and develop decision support tools has often not existed. Information systems have often been redundant, lacking consistency in definition or data collection. Until recently, SAMHSA and the States have employed widely diverse definitions and data elements to measure the outcomes of their program interventions—which is why one of SAMHSA's critical first steps in instituting NOMs reporting is to finalize standard definitions for the specific NOMs for substance abuse treatment, substance abuse prevention, and mental health services, and to adopt standard information technology tools and platforms within SAMHSA to support the collection of the NOMs and other data needed by the agency. The transition from a system built in order to report and monitor financial expenditures for substance abuse and mental health services to one whose function is performance measurement and management is a difficult and complex one, but one aided by the collaboration between SAMHSA and the States.

For SAMHSA and the States, there have not been many universal "lessons learned" from previous experience, and those involved at all levels may feel vulnerable. Although SAMHSA and the States may continue to encounter such resistance, there is general agreement that a "national picture" of substance abuse and mental health services is needed to demonstrate need and to underscore the fact that these services are effective. Indeed, in considering how to institute NOMs reporting by the end of FY 2007, SAMHSA and the States have agreed to jointly develop such national and State pictures using State-reported outcomes. Most importantly, SAMHSA and the States have agreed that a 3-year "phase-in" or transition period is needed before full-scale implementation of a more performance-based Block Grant system can occur. Transition activities will include finalizing developmental measures, assessing State readiness, and targeting technical assistance where needed.

During the past year, SAMHSA has engaged in two major efforts to guide its transition to a performance environment. SAMHSA's Block Grant Re-engineering Report and its data strategy have focused on the training and workforce development necessary in using data to guide programs, and both call for insisting that data be used to support policy decisions about budget allocation and program design. The data strategy addresses the need for a "vertically integrated" system of policy-relevant variables that will eliminate unneeded or duplicate data elements and consolidate Information Technology platforms and software to better meet the analytic and data capabilities of SAMHSA and its grantees.

Overcoming Obstacles to Performance Measurement: During this transition period, SAMHSA and the States need to address other potential obstacles to measuring performance consistently.

SAMHSA's work with the States to identify and define many of the NOMs has enabled SAMHSA to set a clear but limited number of requirements and standards for National Outcomes data collection, and standard data definitions for all elements needed by the agency, including the definitions provided in its FY 2005 SAPT and CMHS Block Grant Applications. SAMHSA is also planning to adopt standard information technology tools and platforms to support its data collection efforts, and consolidate multiple client-data systems. Also, SAMHSA and the States have agreed that the effectiveness of these NOMs should be continually assessed and improved, through testing alternate versions of data elements for developmental measures, for example, to determine which version provides better information. Such careful refinement will go a long way to improve the quality and utility of the measures.

Critical to such improvements is the refinement in the mission of SAMHSA's OAS to include analyses of general interest as well as analyses to support initiation of performance management at the Federal and State levels. This refinement was initiated by SAMHSA's data strategy efforts, which established joint OAS/CSAP/CSAT planning groups to develop an action plan to implement the agreements reached with the States at the December 2004 meeting on NOMs with State substance abuse officials. SAMHSA expects such joint planning between services program managers and OAS managers to be ongoing in support of SAMHSA's overall mission and performance management initiative and will guide future investments. In accordance with SAMHSA's data strategy, the vision is that, ultimately, all data operations will be consolidated into a single organizational unit providing the States with a single reporting point of contact, data standards, and consistently defined measures for all programs.

Obstacles to Performance Management: How performance-based Block Grants are managed, too, has been the subject of some concern. Many of these issues were raised and addressed as a result of the SAMHSA *Federal Register* Notice and comment, among them insufficient collaboration among agencies, which SAMHSA and the States must address on a continual basis. Insufficient or inaccurate analysis of the data collected is another area of concern, which is being addressed to a large degree by the specific involvement of SAMHSA's OAS in analyzing NOMs data. SAMHSA and State collaboration in "painting the national and State pictures" of mental health and substance abuse service outcomes will help both SAMHSA and the States identify information critical to policy and program decisions. SAMHSA will continue to work with the States to provide additional training, technical assistance, and contract support for the analysis of performance data at the provider, State, and national levels to promote accurate analysis and timely reporting of findings.

RESOURCES NEEDED AND CURRENTLY BEING USED TO BRING ACCOUNTABILITY FOR PERFORMANCE TO SAMHSA'S BLOCK GRANTS

Both SAMHSA and the States will continue to need to devote resources adequate to build and maintain the data infrastructure required to gather and report NOMs data—including the purchase of both hardware and software. Perhaps even more critically, they need to reconfigure data systems to focus on the NOMs, and to retrain and hire staff capable of analyzing, reporting, and using the data to manage programs and systems, pursuant to the recommendations of SAMHSA's Block Grant Re-engineering Report.

Although States have reported that they rely on SAMHSA for assistance to upgrade the existing infrastructure, recent information from States shows that approximately 40 States can report substance abuse TEDS admission and discharge information on a timely basis. With regard to prevention, 21 States have received SPF grants that provide for State Epidemiology Workgroups, and the remaining States will receive $200K each to establish such groups. Forty States can report on most of the 20 measures in CMHS's URS, except for measures related to criminal justice involvement, school attendance, and use of evidence-based practices. As noted in the table on NOMs, these three are developmental measures, and SAMHSA and the States are working actively to finalize them.

As detailed below, SAMHSA is ensuring that its 2005 contracts will be used to address State data infrastructure needs and provide technical assistance on NOMs and performance management. Clearly, any full-scale and successful transition to NOMs reporting and managing will depend heavily on continued investment in technical assistance, data collection, data analysis, and data reporting.

Since FY 2001, total funding for SAMHSA's two Block Grants has increased by nearly $500 million, to a request for $2.208 billion in FY 2006, including approximately $50 million for relevant set-aside activities in FY 2005. Of the latter amount, approximately 30 percent is going to the States for data infrastructure support, and just under 50 percent for State technical assistance. As clarified in the table on page 3, on "Resources for Performance Measurement and Performance Management," SAMHSA's investment in data collection, analysis, reporting, and related technical assistance has been consistent, averaging about $50 million each year since FY 2001. The following table provides more specific information on SAMHSA's investments by Center.

Resources for Performance Measurement and Performance Management

(dollars in millions)

SAMHSA Center	Activity	FY 2001 Actual	FY 2002 Actual	FY 2003 Actual	FY 2004 Actual	FY 2005 Estimate	FY 2006 Request
CMHS	State Data Infrastructure (DIG)	6.8	6.8	8.2	0.0	0.0	0.0
	State Outcomes Measurement and Management System (SOMMS)	0.0	0.0	0.0	10.9	10.9	9.8
	State Data Systems	2.7	2.9	2.8	1.4	1.8	1.2
	Technical Assistance	2.7	2.9	2.8	1.4	1.8	1.2
	Program Evaluation	0.0	0.0	0.0	2.4	1.9	0.9
	Subtotal - CMHS	12.2	12.6	13.7	16.0	16.5	13.1
CSAP	SIG: State Data Infrastructure	0.0	0.0	0.0	0.0	0.0	0.0
	State Outcomes Measurement and Management System (SOMMS)	0.0	0.0	0.0	4.3	12.0	12.0
	State Data Systems - SPS/MIS	1.9	1.7	1.8	0.0	0.0	0.0
	Technical Assistance (less SYNAR)	8.2	8.9	6.7	7.9	7.9	7.9
	Program Evaluation	0.0	0.0	0.0	0.0	0.0	0.0
	Subtotal - CSAP	10.1	10.6	8.5	12.2	19.9	19.9
CSAT	State Data Systems	8.7	13.6	8.5	7.3	0.8	0.8
	State Outcomes Measurement and Management System (SOMMS)	0.0	0.0	0.0	0.0	5.0	6.9
	Technical Assistance	12.5	9.9	17.5	3.4	7.4	5.6
	Program Evaluation	1.6	1.9	0.8	1.2	1.8	1.1
	Subtotal - CSAT	22.8	25.4	26.8	11.9	15.0	14.4
OAS	TEDS	3.9	3.9	4.0	4.1	4.1	4.1
	State Outcomes Measurement and Management System (SOMMS)	0.0	0.0	0.0	0.0	5.0	4.4
	Subtotal - OAS	3.9	3.9	4.0	4.1	9.1	8.5
TOTAL		49.0	52.5	53.0	44.3	60.5	55.9

NOTE: All Technical Assistance amounts include only the direct funding for performance measurement and performance management.

The bulk of SAMHSA funding for such activities comes from the Block Grant set-asides. Detail on each Center's funding plans follows:

Mental Health: Since FY 2001, CMHS has devoted $84.1 million to building State performance data infrastructure, including SAMHSA's FY 2006 request. Such activities have

included funding for CMHS's DIG program, as well as funding for State data systems, technical assistance, and related program evaluation. CMHS currently devotes $6M of the first $100M of its general discretionary Programs of Regional and National Significance (PRNS) funding (and 10 percent of funds in excess of $100M) for the DIG program, through which all States and Territories (except for Ohio) are receiving support to gather and report information for CMHS's URS; this information includes the NOMs for mental health. FY 2006 funding for DIG/URS is proposed to total $11.0M in the President's Budget. In FY 2006, funding for the DIG program will be transferred from PRNS to the Block Grant Set-Aside, with no impact on the Agency's 3-year NOMs implementation plan.

Substance Abuse Prevention: Since FY 2001, CSAP has devoted approximately $80 million to State performance measurement and management activities, including its FY 2006 request. In the past, these activities have included technical assistance activities, the Data Coordinating Center and Prevention Platform efforts, as well as various State data infrastructure activities funded through earlier SIG programs. During FY 2005, four CSAP data collection contracts, including those for the Data Coordinating Center and the Prevention Platform, are being consolidated to provide central services to States for data analysis and technical assistance, as well as a single point for State reporting. CSAP resources have been realigned to support epidemiological data collection relevant to the prevention NOMs by each State. Starting in FY 2005, States not currently funded through the SPF SIG will receive a data subcontract through this new consolidated contract in the amount of $200,000.

Substance Abuse Treatment: Over the past 5 years, since FY 2001, CSAT has provided nearly $117 million for State performance data activities, including the FY 2006 request. These activities have included the PPG Technical Assistance Center, a multi-year effort begun in FY 2003 with one-time funding from the proposed National Treatment Outcomes Monitoring System, State needs assessments, State systems technical assistance, and State data infrastructure grants. Beginning in FY 2005 SAMHSA will initiate the SOMMS to support expansion of current State data collection efforts to the requirements of the agreed-upon NOMs for substance abuse treatment. SOMMS activities will be funded jointly by realigning current contract activities in CSAT and OAS. These activities will include data analysis, systems planning, and technical assistance for States, as well as direct funding for the States already capable of reporting NOMs.

Office of Applied Studies: Through its support of State data reporting in TEDS, OAS has provided nearly $34 million for State performance data activities since FY 2001, including its FY 2006 request. With the advent of SOMMS in FY 2005, OAS will also provide approximately $5 million for SOMMS central services, to help States with their ongoing development of performance measurement and management capacity.

IMPLEMENTATION STRATEGY

Consistent with Congressional direction and SAMHSA's vision for the future, SAMHSA is finalizing a 3-year implementation strategy, based on the agreements it reached with State substance abuse officials in December 2004.

The following are specific implementation milestones for this 3-year implementation period. Throughout this time, SAMHSA will be developing consistent data definitions for NOMs as they are finalized and will adopt standard information technology tools and platforms to support the collection of the NOMs and other data needed by the agency.

MILESTONES
NOMS IMPLEMENTATION

YEAR ONE

WINTER 2005

SAMHSA realigns its resources to support State data collection in the first year of NOMs implementation, FY 2005, through the commencement of the SOMMS for substance abuse treatment, the consolidation of data contracts in CSAP for substance abuse prevention, and through continuation of DIG grants for mental health services. Such realignment is reflected in SAMHSA's FY 2006 Budget.

SPRING 2005

SAMHSA and the States will prepare the first report on NOMs, generating NOMs data reports in March 2005 in order to prepare short reports on the National and State Pictures of substance abuse and mental health services.

SAMHSA submits the final version of the Report to Congress, reflecting the 3-year implementation period agreed to by SAMHSA and the States.

SPRING–SUMMER 2005

SAMHSA Centers develop plans for ongoing NOMs implementation, including the following:

- Assessment of potential modifications to NSDUH to support NOMs;
- Analysis of information from pilot tests of NOMs in ATR and SPF SIG;
- Review of Monitoring the Future survey (MTF), Youth Risk Behavior survey (YRBS), and other data bases for potential measures;
- Operationalization of final two mental health NOMs; and
- Revision of specific national surveys on mental health services to include NOMs in order to be able to paint a national picture of the entire organized mental health system.

SAMHSA and the States complete a comprehensive 3-year implementation plan to institute full NOMs reporting by the end of FY 2007.

For substance abuse treatment NOMs, SAMHSA expects to award SOMMS data contracts to the 30 States that are expected to achieve reporting status during FY 2005.

For substance abuse prevention NOMs, States not currently funded through the SPF SIG will receive data subcontracts through CSAP's new consolidated contract in the amount of $200,000 per State.

YEAR TWO

AUTUMN 2005

Year Two (FY 2006) of NOMs implementation begins.

Under SOMMS, an additional 16 States are expected to initiate NOMs reporting during FY 2006, bringing the total number of State contracts to 46.

States continue to strengthen substance abuse prevention data collection through the SPF SIGs and data contracts.

States continue to improve reporting on mental health NOMs through the DIG grants. With revised national surveys, SAMHSA can compare the entire organized mental health system with the component operated by the State mental health agencies, both at the national and State levels.

SAMHSA provides technical assistance to States to support development of record matching capability.

SAMHSA provides systems development planning TA for States needing to develop reporting capability.

WINTER 2005–2006

SAMHSA and the States determine final data elements for developmental measures and modify SAMHSA data collection mechanisms.

SAMHSA develops initial set of performance benchmarks, as a result of completing its analysis of National Institute of Drug Abuse (NIDA) clinical trials data.

SAMHSA and the States again collaborate to produce a second report on NOMs, with national and State pictures of substance abuse and mental health services, for making policy and resource decisions at national and State levels.

SPRING–SUMMER 2005

SAMHSA and the States will continue to refine and finalize NOMs, establishing consistent measurement of each by all States.

SAMHSA and States continue to work to increase the number of States able to report all NOMs data.

YEAR THREE

All States will report on all NOMs by October 2007 and will continue to work with SAMHSA to develop annual and special reports on NOMs.

CONCLUSION

It is SAMHSA's position that significant progress and accomplishments have already been and continue to be achieved in transforming its two Block Grants into performance-based programs. By being clear about what is being achieved, who is responsible, and who should be held accountable under SAMHSA's Block Grants, SAMHSA and the States will be in a better position to be answerable, collectively, for the documented outcomes of mental health and substance abuse services made available to Americans with or at risk for mental and substance use disorders. SAMHSA and State Agencies will be visibly accountable for helping ensure that every American has the opportunity for achieving a fulfilling life in the community.

SAMHSA is firmly committed to bringing accountability for performance to its Block Grants as well as to its other key programs. It fully agrees with Congress that such accountability is at the heart of good programs and good management. To reiterate, SAMHSA remains dedicated to providing leadership for the development of performance measurement and accountability in SAMHSA's Block Grants through implementation of the NOMs for mental health, substance abuse prevention, and substance abuse treatment. This process is well established, but is not complete in every State at this time. As SAMHSA and the States embark on these changes, SAMHSA would like to discuss both its current activities and its plans with Congress. SAMHSA and Congress can then work together to identify what else may be needed for full implementation of accountability for performance in SAMHSA's Block Grants.

APPENDIX A

CONGRESSIONAL REQUIREMENT FOR REPORT ON PERFORMANCE PARTNERSHIPS

From **PUBLIC HEALTH SERVICE ACT**

SEC. 1949 [300x-59] PLANS FOR PERFORMANCE PARTNERSHIPS

(a) DEVELOPMENT. – The Secretary in conjunction with State and other interested groups shall develop separate plans for the program authorized under subparts I and II for creating more flexibility for States and accountability based on outcome and other performance measures. The plans shall each include--

(1) a description of the flexibility that would be given to the States under the plan;
(2) the common set of performance measures that would be used for accountability, including measures that would be used for the program under subpart II for pregnant addicts, HIV transmission, tuberculosis, and those with co-occurring substance abuse and mental disorders, and for programs under subpart I for children and serious emotional disturbance, and adults with serious mental illness and for individuals with co-occurring mental health and substance abuse disorders;
(3) the definitions for the data elements to be used under the plan;
(4) the obstacles to implementation of the plan and the manner in which such obstacles would be resolved;
(5) the resources needed to implement the performance partnerships under the plan; and
(6) an implementation strategy complete with recommendations for any necessary legislation.

(b) SUBMISSION. – Not later than 2 years after the date of the enactment of this Act (October 17, 2000), the plans developed under subsection (a) shall be submitted to the Committee on Health, Education, Labor and Pensions of the Senate and the Committee on Commerce of the House of Representatives.

(c) INFORMATION. – As the elements of the plans described in subsection (a) are developed, States are encouraged to provide information to the Secretary on a voluntary basis.

(d) PARTICIPANTS. – The Secretary shall include among those interested groups that participate in the development of the plan consumers of mental health or substance abuse services, providers, representatives of political divisions of States, and representatives of racial and ethnic groups including Native Americans.

APPENDIX B

ACRONYMS USED IN REPORT

ATR	Access To Recovery grant program
CAP	Nevada's Consumer Assistance Program
CMHS	Center for Mental Health Services (SAMHSA)
CAPT	Center for the Application of Prevention Technology
COSIG	Co-occurring State Incentive Grants
CSAP	Center for Substance Abuse Prevention (SAMHSA)
CSAT	Center for Substance Abuse Treatment (SAMHSA)
DASIS	SAMHSA's Drug and Alcohol Services Information System
DIG	Data Infrastructure Grants
HIPAA	Health Insurance Portability and Accountability Act
MDS	CSAP's Minimum Data Set
MHST	Mental Health Systems Transformation
MTF	Monitoring the Future survey (NIDA)
NASADAD	National Association of State Alcohol and Drug Abuse Directors
NASMHPD	National Association of State Mental Health Program Directors
NIDA	National Institute on Drug Abuse (NIH)
NOMs	National Outcome Measures
NSDUH	SAMHSA's National Survey on Drug Use and Health
OAS	Office of Applied Studies (SAMHSA)
OMB	Office of Management and Budget
PART	OMB's Program Assessment Rating Tool

PPG	Performance Partnership Grant
PRNS	Programs of Regional and National Significance
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPT	Substance Abuse Prevention and Treatment
SIG	State Incentive Grant
SOMMS	State Outcomes Measurement and Management System
SPF	Strategic Prevention Framework
TEDS	SAMHSA's Treatment Episode Data Set
TOPPS	Treatment Outcomes and Performance Pilot Studies
URS	CMHS's Uniform Reporting System
YRBS	Youth Risk Behavior Survey (Centers for Disease Control and Prevention)